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ABSTRACT

Background: The Better Care Fund (BCF) is the first and only national policy in England that has legally mandated the use of pooled budgets to support local health and social care systems to provide better integrated care.

Methods: We report qualitative findings from the first national multi-method evaluation of the BCF, focusing on the implementation of the BCF, perceptions of progress, and expected impacts among key stakeholders. Interviews were carried out with 40 staff responsible for BCF implementation in 16 local health and social care sites between 2017 and 2018.

Findings: Study participants reported their experiences of implementation and we present these in relation to three themes: organisational issues, relational issues, and wider contextual issues. Participants stressed the practical and political challenges of managing pooled budgets and the complexity of working across geographical boundaries. In a context of unprecedented austerity, shared vision and strong leadership were even more vital to achieve collaborative outcomes.

Discussion and conclusion: Pooling budgets through the BCF can lever closer collaboration between sectors and services. Shared vision and leadership are essential to develop and foster this closer collaboration. Although some successes were reported, the study highlights that there are major cultural, operational and territorial barriers to overcome.

KEY WORDS

health and social care; integration; Better Care Fund; pooled budgets; evaluation

Introduction

Integrating health and social care services is a policy goal for many governments to address demographic change and the rising costs of health care.¹ An ageing population and the rapid rise in the number of people with chronic conditions, multimorbidity, and complex care needs has highlighted the need for more integrated systems and services that bring together the different care sectors. In England, differences in the evolution of health and social care systems in terms of their professional culture, financing and political accountability mean that services have remained largely fragmented.²⁻⁴ Among the key challenges has been the historical division between the centralised, free-at-point-of-delivery National Health Service (NHS) and the local, means-tested system of social care. Health services are purchased by Clinical Commissioning Groups (CCGs) while (publicly funded) social care, which includes a range of practical support to meet needs that arise from ageing, disabilities, and ill-health, such as residential and nursing care, adaptations, meals and home care, is purchased by elected local authorities as part of their wider responsibilities for promoting the wellbeing of local populations.

Announced in 2013, the Better Care Fund (BCF) sought to overcome some of these historical divisions and to improve integrated working between local health and social care systems.⁵ The BCF is “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”.⁵ It requires CCGs and local authorities in the same geographical area to agree a plan on how to use their allocation of a protected (ring-fenced) budget to improve integrated care. The budget is assigned from the national NHS allocation, and it may be voluntarily added to by CCGs and local authorities.⁶

Underpinning the BCF was an assumption that integrated working with social care would deliver “better, more joined-up services to older and disabled people, [...] keep them out of hospital and [...] avoid long hospital stays”.⁵ Its core aspiration was to reduce pressure on acute care and this is reflected in the national policy and performance framework for the BCF, which focuses on reducing unplanned admissions and length of hospital stays, including delayed transfers of care.⁶ There are

incentives for local systems to improve according to central criteria: well performing areas gain increased autonomy and less burdensome reporting requirements to the centre.⁷

The BCF is the first and only national policy in England to legally mandate the pooling of health and social care funds, and it is the principal policy instrument driving local health and social care systems towards the government's stated goal for the complete integration of health and social care budgets in England by 2020.⁶ It was implemented alongside wider attempts to integrate care, most importantly the sustainability and transformation partnerships (STPs), which seek to bring local health and care leaders together to plan around the long-term needs of local communities.⁸ Taken together, these activities reflect a localism agenda in contemporary English health policy that emphasises placed-based solutions to system challenges.⁹ The BCF will be of much international interest as other health care systems develop legal and financial mechanisms to support integration.^{10, 11} Although there is some evidence that supports the use of integrated services, few studies examine the impacts of policies promoting integrated care through pooled budgets.¹⁰ Evidence suggests that financial integration can be difficult to implement and does not necessarily reduce barriers between services.^{12, 13} Despite legal and regulatory support there may be practical problems in transferring funding across sectors, and cultural, professional and operational differences are often deeply embedded.¹² Studies of other integration initiatives meanwhile suggest that their effectiveness, and factors that facilitate or hinder success, depend significantly on the local context in which the intervention takes place.¹⁴⁻¹⁸

Against this background we conducted the first, national multi-method evaluation of the BCF in England over a three year period (2016-2018) and we here focus on the implementation of the BCF and perceived impacts so far. We report local experiences in relation to three key themes: organisational issues, relational issues, and wider contextual issues. Our findings raise important questions about the potential of the BCF to lever collaboration between services and sectors. We reflect on wider lessons learned about the barriers and facilitators to integrating health and social care as countries elsewhere experiment with integrated care models in response to system pressures.

Methods

Qualitative data collection comprised in-depth, semi-structured interviews with individuals leading implementation of the BCF within local health and social care systems in England ('BCF programme sites'). We aimed to recruit sites that varied in terms of geography and size, total and per capita BCF funding, and integrated care services. Sites were recruited through national and local BCF policy support networks and were asked to contact the evaluation team directly. Feedback from potential participants indicated that lack of time, capacity, and changes in local planning impeded sites' participation. We therefore attempted to improve recruitment by expanding the networks through which we advertised our evaluation and followed sites up directly by email and telephone. Nevertheless the resulting sample was smaller than anticipated. However we managed to achieve diversity around the key criteria.

A total of 16 sites participated and 40 individuals from both health and social care organisations within sites were interviewed over a 12-month period between January 2017 and January 2018. The recruitment method for interviewees did not allow us to estimate the number of declining individuals. The interview topic guide was informed by a preparatory review of the literature on implementing integrated care.¹⁹ Interviews focused on views and experiences of BCF implementation, perceptions of progress, and expected impacts. Most interviews were carried out by telephone with five being carried out face-to-face. Three group interviews were conducted at local sites' request for pragmatic reasons, which included 15 people in total (two groups of three and one group of nine). Table 1 presents study participants by organisation and professional role.

[INSERT TABLE 1]

All interviews were recorded and transcribed verbatim. A coding framework informed by the interview topic guide was piloted by all authors on a selection of transcripts. Two members of the research team then used the framework to double code six transcripts to ensure coding consistency. Themes and sub-themes were subsequently discussed with the wider team and the final coding

framework was refined and agreed. Coding of all data was then carried out using NVivo software, and the framework was used to interpret the data. Ethical approval for the study was conferred by the National Research Ethics Service (NRES) Committee (reference 16/IEC08/0011) and HRA (Reference 200256). The study also received research governance authorisation for each participating CCG and local authority.

Results

Sites were attempting to develop existing joint working arrangements through the BCF, focusing on services that would help them meet national BCF performance indicators to reduce unplanned hospital admissions and delayed transfers of care (DTOC). Specific services varied, but key areas of provision included intermediate care (such as reablement and rehabilitation services), discharge schemes, and case management and care coordination through, for example, multi-disciplinary teams and co-location of services. Many sites also attempted to develop their infrastructure for integrated working and improve data-sharing processes between health and social care organisations.

Our analysis of local areas' experiences of implementation of the BCF identified three key themes: organisational issues, relational issues, and wider contextual issues, which we report in the following, along with perceptions of early impacts.

Organisational issues

Identified organisational issues concerned both the practical and political challenges of managing pooled BCF budgets, and the challenges arising from working across geographical and administrative boundaries.

Managing pooled budgets

Under the BCF, local health and social care systems were legally required to spend BCF funds through a pooled budget. Specific governance arrangements were locally agreed, and sites could combine existing pooled budgets and other funds with the BCF.

To simplify administrative processes, some sites opted to manage the BCF as a separate finance stream within existing pooled budget arrangements rather than hold it as a completely separate budget. However, participants explained that disaggregating BCF spending and attributing outcomes to spending was more difficult, as integration activity was measured as a whole in the context of the overall pooled budget. Aligning spending programmes was problematic where contributions to the BCF involved reallocating funds from organisations' other financial streams, and money was tied up in different budgeting periods. These issues caused tensions particularly for finance teams who were concerned about having to (re)balance budgets.

Arrangements for sharing financial 'risk' (potential losses) were also contested and subject to time-consuming negotiations where organisations were concerned about who would bear financial responsibility for joint initiatives funded through the BCF:

“There’s some debate as to longer term whether that will even continue to be a pooled budget because of the challenges. And some of the decisions the [organisation] have taken in the last couple of years in trying to bring in a financial recovery plan, that will almost, you know, destabilise the pool...it caused a lot of angst in negotiating, agreeing that.” [Local Authority Senior Manager]

Tensions about respective financial contributions and how and where money should be spent also arose. These difficulties tended to occur where sites were facing particularly intense financial pressures and relationships were strained already. In some areas, a lack of shared expectations about BCF aims hindered progress: some health organisations were unhappy that the BCF diverted resources from health to support social care; meanwhile some local authorities felt that the BCF was too concentrated on relieving hospital pressures. A small number of participants also expressed frustration that the BCF reduced their overall budget flexibility:

“To some extent it put the money more at the forefront...money was obviously always important here, without a shadow of a doubt, but it became about how much money is mine and how much money is yours, rather than the idea of actually this is just money in the

locality. And certainly for us here it probably--, it probably, by the second year of the BCF, set us off track a bit while we went back and worked through the complexities of understanding what was in that £10.5 million.” [Local Authority Senior Manager]

Working across geographical boundaries

BCF implementation required staff to develop plans and apply changes across organisational boundaries. However, the geographical areas and populations served by health and social care organisations were often not aligned. For example, in the majority of sites interviewed, hospital trusts provided care across several CCG and local authority areas. This caused problems for implementing BCF initiatives that required hospital staffing arrangements or procedures to be configured differently for separate BCF plans:

“Because of our geography we have a bit of a complication because I work coterminous with the CCG but not coterminous with the [hospital trust] and obviously the [hospital trust] wants to have the same processes across its footprint... because the hospital, if they’re going to change the way they do it, they want to do it the same across their footprint. So we’ve got this knife at the core in the middle of [place name] but basically we’re in the corner of everybody else’s footprint and that goes in all different directions.” [Local Authority BCF Lead]

Often CCGs were working with several local authorities in one geographical area, or vice versa, with different financial positions and population needs. Here, sites attempted to develop shared aspirations regarding BCF programmes at the strategic level while reflecting more specific local priorities. Where BCF schemes involved a greater number of partners, more time and resources needed to be devoted to communicating, project managing and coordinating changes so that pace and progress was aligned:

“Everyone starts from a slightly different point and you’re trying to tailor what you’re doing to make it relevant, but at the same time, you’re trying to achieve the same end goal. So different bits of the system are running at different degrees of heat.” [LA Director]

A key finding was that, at the time of BCF implementation, the majority of sites were starting to develop proposals for sustainability and transformation partnerships and were considering how to align plans. Overlapping geographic boundaries had the potential to cause confusion and disruption to planning for each respective policy and resource allocation decision. Study participants were frustrated that this diverted attention and resources from frontline implementation. While the different initiatives were understood as part of a larger step towards overall integration, participants perceived these to sometimes have the unforeseen consequence of creating conflict:

“So bringing all of those together trying to get some agreement on an STP footprint whilst simultaneously trying to have a Better Care Fund plan that relates to one small part of that footprint...the complexity... it felt like no one had really thought through how these were going to work in practice ” [Local Authority Commissioner]

Relational issues

Relational issues, in the sense of how comfortably and effectively organisations interacted with each other, were seen to have had a major influence on BCF implementation. Participants highlighted the importance of shared vision, leadership, and overcoming differences between organisational and professional cultures.

Shared vision and leadership

Progress with BCF implementation was attributed to a strong sense of shared vision and ownership over BCF plans and confidence that leaders would work together for lasting change. A culture of trust, willingness to share information, and the avoidance of ‘blame’ were viewed as critical to managing pooled budget arrangements. Participants explained that while disagreements about where and how to spend money could still occur, managing shared finances and resolving disputes was easier where leaders had agreed to relinquish some control and accept joint responsibility for decision-making. Where partners were reluctant to do this, sites often became caught up in negotiating contractual or legal issues:

“a lot of the things that stop integrated working is when people don’t have the same vision of what they’re trying to deliver... what I picked up was the ability of the organisations to share a vision, work together, they’d made it very clear, and some of that came from the clinical chair and the chief officer we have, that they’d made a decision that they weren’t having any of this “It’s their fault, it’s your fault”, any of that nonsense.” [CCG Clinician]

Appointment of a BCF ‘lead’ or ‘champion’ was also seen as helpful in many sites to articulate a clear vision for integrated working, coordinate and project manage implementation, and mobilise support among stakeholders.

Professional and operational differences

Strong team leadership and fostering shared beliefs about the benefits of integrated working among frontline staff was important for progressing integrated care schemes themselves. Yet differences in professional cultures and organisational procedures between health and social care teams were often deeply entrenched:

“I mean one of the biggest barriers is buy-in and getting cultural change...getting the cultural and hearts and minds challenge met. That’s the first thing.” [Local Authority Commissioner]

In one site for example, professional differences manifested during the delivery of a palliative care scheme. Social care staff emphasised support for patients to die in their place of choice (at home), while nursing and occupational therapy staff gave more priority to managing medical risk. More common were difficulties in reconciling organisational processes and perceived inflexibilities. For instance, one site had attempted to develop a novel joint brokerage scheme across health and social care organisations to signpost people requiring continuing health care to local support. However the funding and payment options between different providers were viewed as too complex and the scheme was not implemented.

Clarity regarding processes and roles enabled staff to feel more confident about BCF initiatives. Joint posts between health and social care organisations were seen as useful for improving understanding of

others' work and heightening awareness of issues such as professional language that could influence working relationships. Co-locating services (for example multidisciplinary teams) were also perceived to help improve communication and problem-solving among staff, however difficulties due to separate governance and organisational procedures often persisted.

Wider contextual issues

In addition to the factors reported above, the wider contextual issues of financial austerity and local capacity for implementation also affected the pace of progress.

Financial austerity and capacity for implementation

The wider context of financial austerity had conflicting effects on BCF implementation. Participants reported that financial pressures had prompted partners to seek collaborative solutions to shared problems, however such pressures were also a barrier to progress. Financial pressures influenced the extent to which sites were able to 'top up' their minimum contribution to the BCF, devote resources to planning and implementation, and transition from existing service arrangements (for example by 'double-running' or managing closure of current provision) while new integrated care services were being implemented under the BCF. In particular there was a view that because the BCF involved redirecting existing funding and was not 'new' or additional money, it limited the extent to which sites could invest in new services and experiment. In this context, some sites felt compelled to use the majority of their BCF budget to maintain existing provision:

“the problem was there was no money, it was all old money...as such you're very limited in what you can do in terms of changing what is done because, you know, demand is there” [LA BCF Lead]

Where capacity such as dedicated staff time and financial resources was limited, a small number of participants reported that the BCF policy framework enabled them to focus resources and identify key areas for investment and/or improvement. In implementing BCF plans, participants reflected that learning from other areas could be helpful, particularly where sites were adopting common approaches to integrated services, such as multidisciplinary teams or discharge schemes. However,

participants stressed the importance of recognising specific local contexts and starting points. In determining whether approaches were transferable, issues such as financial position, local workforce and provider market appeared significant. For example, challenges with workforce recruitment and retention in the domiciliary care and care home sectors influenced sites' ability to place people quickly into suitable services. Several participants remarked that their local care sector was struggling to cope with the increased demand for short term beds and intermediate care packages as sites faced pressure to rapidly discharge patients from hospital under BCF plans. Finally, some participants felt that while the national support available for BCF implementation was comprehensive (including webinars, online forums and regional events), it was often under-utilised locally due to lack of staff time and capacity pressures.

Early impacts

Although progress with BCF implementation was mixed across sites at the time of interview, participants reported a number of early successes and positive impacts on integrated working. A key impact for many sites was increasing local opportunities to collaborate and consolidate partnerships for joint working, particularly where integrated working was at an early stage:

“I think some of the conversations were embryonic and this has probably accelerated them and kind of helped with the process.” [Local Authority Integration Manager]

The BCF also provided a clear steer for partners to focus discussions where organisations had struggled historically to agree specific plans. This was seen to be especially important in the absence of alternative legal mechanisms and levers to encourage collaboration. In other areas, the BCF policy framework had helped organisations ‘sense-check’ progress towards integrated working and strengthen and expand existing relationships:

“We’ve learnt a lot...because people got around the table that hadn’t been there before...”
[CCG Senior Manager]

An important aspect raised was improvements to the patient pathway and experience of services so that they were more person-centred. Examples included developing more responsive care packages,

such as those that allowed people to stay in their own homes; social prescribing that reflected people's holistic needs; and training care home staff, for instance regarding discussing individual preferences for death. Another common approach was using the BCF to fund a single process for assessing care needs that could then be shared across health and social care organisations. This aimed to reduce duplication and burden for both patients and assessors.

Participants were more varied in their views about the impact of the BCF in achieving national indicators for reductions in unplanned hospital admissions and delayed transfer of care rates. Some sites were beginning to realise progress towards the latter as a result of greater investment in step down (intermediate) services to support transitions out of hospital, for example reablement and improvements to discharge processes. This is also reflected in our quantitative evaluation, which found intermediate care to be the largest area of investment reported by sites.¹⁹ However, the potential impact of BCF schemes on unplanned hospital admissions was described as less certain due to the complexity of determinants of admissions, and difficulties in measuring and attributing the effects of services that are preventative in nature, such as home care and community-based schemes. Some participants meanwhile expressed concerns that the performance measures specified in the BCF policy framework were too narrow in their focus on health system outcomes. Nonetheless, others were spending BCF in the expectation that leaving hospital in a more timely way would encourage a return to independence more quickly and improve quality of life for patients.

Discussion and conclusion

The BCF attempted to improve integrated working among local health and social care systems in England through compulsory pooling of specified funds. Consistent with international evidence¹⁰⁻¹² our findings highlight the political and practical challenges associated with pooled budgets, such as agreeing and aligning spending programmes, operationalising joint responsibility for financial decision-making and risk, and managing shared budgetary processes. These challenges were intensified by the wider resource constraints facing local sites, which influenced their capacity and enthusiasm for implementation, and the complexities of redirecting existing resources to meet national BCF requirements.

Underpinning the use of pooled budgets is the principle that separate funding streams can create and reinforce service inflexibilities and correspondingly narrow and fragmented approaches to meeting the needs of patients.¹² Our findings suggest that the BCF, overall, helped to promote greater awareness among local decision makers of the interdependencies in health and social care sectors affecting priorities for reducing unplanned hospital admissions and length of stay. Many sites made progress in developing intermediate care services to support timely hospital discharge. However there were tensions in realising these objectives where it appeared that system benefits, that is reduced pressures on services and their associated costs, would be experienced in the acute sector. These findings point to the importance of fully aligning incentives in implementing pooled budgets; alone pooled budgets cannot address deeply entrenched differences between decision makers in each sector who continue to operate with reference to their own set of priorities, constraints, and budgetary pressures.¹² These differences are reinforced by national accountability systems that remain focused predominantly on the performance of individual organisations rather than health and care systems as a whole.

Challenges in BCF implementation were further amplified by the introduction of sustainability and transformation partnerships at the time of our interviews. This frequently diverted planning and resources away from BCF implementation and fuelled uncertainty over future organisational boundaries for health and social care organisations. The impacts of inter-organisational working through sustainability and transformation partnerships on aspirations for health and social care integration are unclear as yet, but our findings highlight that the BCF will need to be reconciled and (re)negotiated locally as sustainability and transformation partnerships' plans unfold.

More widely, our findings attest to a number of issues pertinent to the implementation of integrated care initiatives.¹⁴⁻¹⁸ Shared vision and strong leadership were vital to align resources and engage wider stakeholders in implementing plans, especially frontline staff. Lack of dedicated organisational capacity (personnel and resources) meanwhile impaired progress. Particularly where the benefits of integrated working are likely to be realised in the longer term, higher budgets may well be needed initially to support transitions, sustain momentum, and avoid unilateral decision-making.

There are some limitations to our study. The breadth of our evaluation was limited by the relatively small sample of sites that responded to our requests for interview. In addition, the relatively short time frame over which our evaluation had to be carried out means that we were unable to assess longer term outcomes of the BCF policy. Future research should identify pathways to successful implementation and specific outcomes in order to build on the empirical work presented here. There is a further value in evaluative health research that identifies interventions that promote person-centred goals and outcomes of integrated services: consistent use of validated measures of views and experiences of patients and their carers is needed in current evidence regarding integrated care initiatives and their inclusion would improve our understanding of the impacts of integrated care.²⁰

The challenge in England of implementing integrated services to support the growing health and complex care needs of an ageing population is being transferred to local initiatives, and pooling local health and social care budgets through the BCF policy is one such approach. However it is clear that those seeking to address the challenge of integration currently lack a clear evidence base and resources to support changes to prevailing patterns of services. Stemming from their longstanding institutional separation, there are major cultural, operational and territorial barriers between organisations and professions that still need to be overcome.^{2,3} Given this, as others have argued,⁴ integration is likely to be a long-term pursuit.

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The Author(s) declare(s) that there is no conflict of interest.

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